

THIRD-PARTY PAYMENT MECHANISMS IN HEALTH MICROINSURANCE: PRACTICAL TIPS AND SOLUTIONS

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Some health microinsurance (HMI) schemes require that patients pay cash at the time of receiving health care services, and then seek reimbursement from the insurer at a later date. For low-income households, this can be a severe financial barrier. One common way to alleviate this barrier is to set up a third-party payment (TPP) mechanism with selected health care providers.

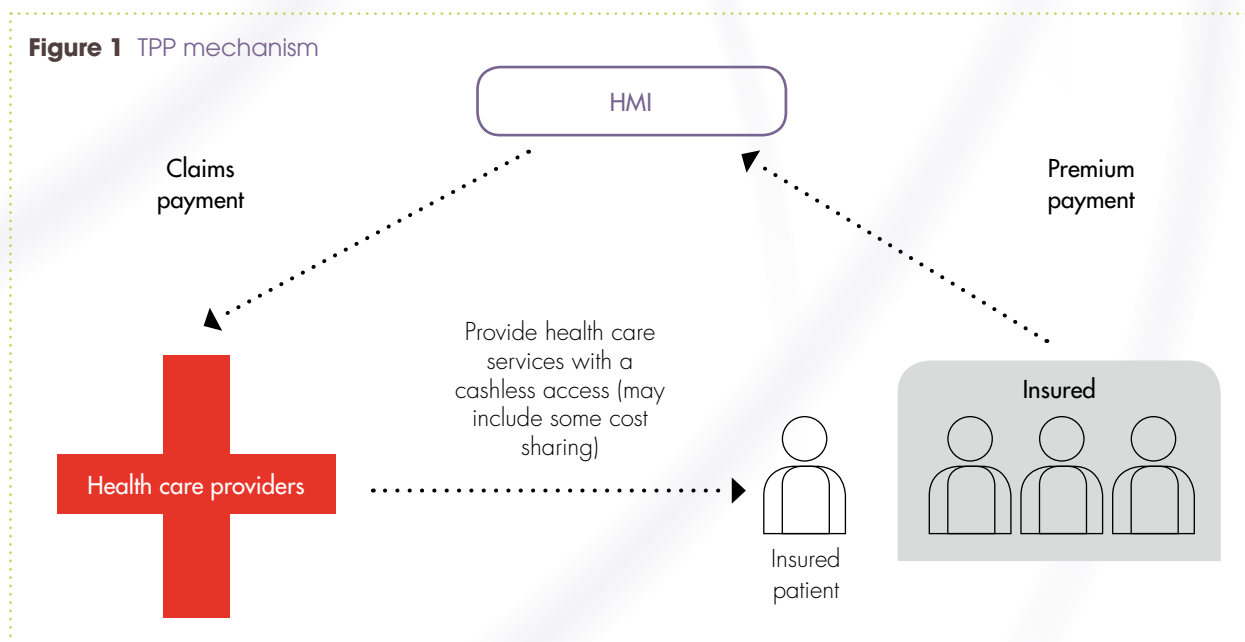
A TPP mechanism is a model for claims payment in which insured patients are not required to pay the entire cost of health services covered by the HMI scheme at the time the services are rendered (see Figure 1). With the exception of any cost sharing (e.g. co-payment, deductible), an insured patient has no out of pocket payment at the time of service; a third party (the HMI scheme or another entity on

behalf of the HMI scheme) pays the health care provider for the services provided to the patient.

This note¹ draws from the experiences of HMI practitioners in developing countries and is based on the detailed review of seven schemes, interviews with 19 experts and a survey of practitioners in 21 countries. It identifies lessons related to the set-up and management of TPP mechanisms to provide “cashless”² access to insured persons.

HMI schemes with a TPP mechanism need to establish and maintain minimum standards for each participating provider and for the overall network of providers. These standards should address the adequacy of three key dimensions: access to care, cost and quality of care. Tips and solutions for these three dimensions are summarized below.

Figure 1 TPP mechanism



¹ This brief is excerpted from Microinsurance Paper no. 13, which includes the relevant citations and details on methodology and the cases reviewed. The paper is available at www.ilo.org/microinsurance. Pascale Le Roy is part of the Groupe de Recherche et d'Échanges Technologiques (GRET) and Jeanna Holtz works for the ILO's Microinsurance Innovation Facility.

² TPP mechanisms can also be referred to as: cashless HMI schemes, cashless claims arrangements, cashless systems, or cashless benefits. The term cashless can apply regardless of whether the insured patient's access is truly cashless or whether it involves cost sharing.

ENSURING ACCESS TO HEALTH CARE

The first dimension of adequacy relates to access to services through selected health care providers. As with regular HMI schemes, the regulatory environment, and the location and service offerings of health care providers must be assessed to evaluate which health care providers could be relevant partners for the HMI scheme. HMI schemes seek health care providers that agree to:

- Meet minimum standards for the quality of health care, ideally with the oversight of a medical advisor from the HMI scheme;
- Conduct regular monitoring of quality of care, both internally and/or by external health care professionals;
- Receive payment for services provided under the terms agreed to, and use rational fee schedules;
- Utilise transparent billing and accounting systems;
- Follow an acceptable procedure to verify insured patients' eligibility;
- Share information with the HMI scheme regarding insured members' utilisation of health care services; and
- Potentially support the presence of a HMI scheme staff (e.g. a help desk) on-site to assist members of the HMI scheme.

MANAGING COST

Once potential health care providers have been selected, the success of a TPP mechanism depends on implementing an appropriate payment method and aligning financial incentives to encourage proper care. In order to control costs, the HMI scheme also needs to manage moral hazard and fraud risks arising from both health care providers and clients.

Negotiating the payment method

With a TPP mechanism, HMI schemes usually pay contracted health care providers according to a pre-determined method of payment. Four common payment methods are outlined below. Each method gives different incentives and disincentives for providers to control the cost and quality of services:

Retrospective payment on a fee-for-service basis: health care providers are paid (a la carte) for each service performed that is covered by the HMI scheme. Fee-for-service payments can be based on a fixed fee schedule per service, or per group of services (e.g. pay X for a hernia repair). More commonly, fee-for-service payments are based on a percentage of the health care provider's billed charges (i.e. where the "discount" equals the "per cent off" billed charges). In this case, payments are not fixed; they depend on the charges submitted. Discounted fee-for-service arrangements are therefore easily manipulated (e.g. by simply inflating billed charges). Establishing an equivalent fixed fee (at least for high volume services) may be one method to mitigate this; another approach is to analyse health care provider charges to identify suspicious trends or outliers for intervention.

Retrospective case-based payment: health care providers are paid an all-inclusive (sometimes called "global") amount, typically for all services provided in connection with a hospitalisation or an episode of care that may include pre- and post-hospitalisation care. Per case payments can be constant, or vary according to variables such as diagnosis or age of patient that can greatly influence the cost of treatment.





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ding primary, secondary and tertiary care. Capitation may be an appropriate way to compensate providers for high frequency/low cost (i.e. more predictable) health events, including primary (outpatient) care. This is because it is easier to estimate in advance how often persons will seek primary health care in a given period and the approximate cost for this. Capitation works best where a critical mass of enrolment can be achieved with a given health care provider and where the provider can deliver the full range of care. Capitation can reduce administrative costs, because claims do not need to be processed for each encounter (see Box 1).

Payment methods that transfer some financial risk to health care providers (case-based, per day or capitation) have greater potential to contain costs than fee-for-service payment, but require additional measures to control for quality of care. These methods are usually more difficult to negotiate with health care providers. Mixed payment methods (i.e. capitation for primary health care services and per case for hospital cases), may be suitable in many respects but often complicate administration and increase management costs.

Limiting moral hazard and fraud

Moral hazard and fraud are standard challenges associated with health insurance. Since insured patients in HMI schemes with a TPP mechanism do not bear the cost of health care at the time of service, the incidence of moral hazard can increase as clients may view the care as free and use additional services that may be unnecessary. Similarly, health care providers can view the insurer as having greater financial capacity and thus may see an increased opportunity to deliver services that are covered, but which may not be medically necessary.

Retrospective payment per day: health care providers are paid an all-inclusive amount per day of hospitalisation. Per diems can vary by type of service or bed, such as intensive care versus surgical or medical ward services.

Prospective payment by capitation: health care providers are paid a fixed payment per enrollee – per “head” – for a defined period, usually one year. Capitation payments are not affected by utilisation of services (volume and type) by the insured; they are made prospectively (in advance) to the health care provider that the enrollee selects. Capitation may apply to a specific health care service or set of services, such as primary (outpatient) care, or capitation can apply at a “global” level, i.e. for all health care inclu-

Box 1 GRET-SKY's Experience with Capitation

GRET SKY (Cambodia) wanted to provide free access to primary health care. GRET SKY felt that capitation was the best method because it could limit the administrative costs and the financial risk for the HMI scheme. Establishing a capitation payment arrangement required lengthy negotiations to address concerns of public health care providers to generate sufficient revenue. Several factors made this negotiation successful:

- The scheme had support from the Ministry of Health as well as the local health authority.
- The first contracted public health facilities were supported by an international NGO that was open to alternative payment methods.
- The contracted public health facilities had excess capacity and were seeking more patients.
- All calculations to determine the capitation amount were transparent to all parties.
- GRET SKY compensated any financial loss by the provider during the first year if the charges for services rendered exceeded the capitation amount.
- When the number of insured clients was limited and providers were reluctant to participate, the capitation payment per client was “boosted” in order to guarantee a minimum amount of revenue to participating providers. This per member “capitation boost” gradually decreased as the membership increased, and then was constant.

GRET SKY evaluates appropriateness of the capitation amount annually to achieve financial viability for both parties. The capitation amount has progressively decreased for many contracted health providers, as rates were initially “boosted” to encourage participation. GRET SKY's experience showed that it took approximately two years to eliminate the subsidy of capitation rates.



Examples of how HMI schemes **manage moral** hazard include:

Product design: limit maximum total benefit per person for hospital care. This can be an effective way to limit risk exposure but this limits benefits for necessary care for those who incur catastrophic claims. This in turn can reduce both the real and perceived value of the HMI scheme from the client perspective, making a “right balance” difficult to achieve.

Claims administration: analyse claims and utilisation data. A variety of indicators related to high (or low) costs or utilisation can help identify instances of moral hazard. These might include: number and cost of claims, frequency and cost per unit, average length of stay for hospitalisations, incurred claim ratio, billed charges as a per cent of total capitation (for schemes with capitation). Routine (e.g. monthly) monitoring of key performance indicators is essential to monitor a HMI scheme’s performance and identify potential areas of moral hazard or fraud. Interpreting these indicators requires access to a developed information system and the knowledge to analyse data.

Medical management: implement utilisation management controls. Interventions such as pre-authorisation or concurrent review can manage both cost and quality prospectively and concurrently and reduce moral hazard. However, such activities (e.g. implementing treatment guidelines) can be complex and costly to administer, and are often perceived as a hassle by providers as well as clients. For example, First Microinsurance Agency (FMiA) in Pakistan used to review claims twice before being sent to the insurer for payment: a first review is done at the time of discharge by a sales officer, who has the option to refer questionable claims for a second review to a FMiA medical advisor.

Lessons from case studies show that HMI practitioners understand that a zero fraud target is not realistic.

Strategies to **control fraud** include:

- **Issue a family or individual insurance card**, usually with a photo. A few surveyed HMI schemes use smart cards to verify eligibility.
- **Check identification through liaison officer:** A liaison officer can foster a “client culture” by assisting clients to better understand the benefits of their scheme, and ease the burden on health care providers to verify eligibility. Having an insurance liaison inside contracted health facilities entails a risk of internal fraud. Microcare in Uganda used to rotate nurses managing the liaison function at a health care provider to limit the potential of fraud.
- **Require pre-authorisation of high-cost services and hospitalisations.** A gate-keeping function to limit unnecessary health care utilisation is especially important when providers receive fee-for-service payments. Typically, the insured person must request an authorisation from the HMI scheme to access health care services. Timeliness of the authorisation is important to make sure clients get value from the scheme. Pre-authorisation remains problematic for primary health care, due to the higher frequency of services, and less clear criteria available for their use.
- **Provide accurate and up-to-date lists of eligible clients** to health care providers. This is critical for schemes using capitation payment. This is simpler for HMI schemes that limit enrolment to defined periods, but more demanding for HMI schemes that maintain a continuous enrolment such as GRET SKY, which has clear procedures and deadlines to ensure that eligibility data are provided to health care facilities early each month.



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MANAGING QUALITY WITH A TPP MECHANISM

Quality of care may be defined using objective and subjective criteria and can be measured with clinical and non-clinical or service indicators. Clinical outcomes, such as infection rates, are examples of objective indicators. Since clinical outcomes data and benchmarks are often not available, other criteria may be used as a next best alternative. For example, the credentials of health care providers are often evaluated as a proxy for clinical quality. Sometimes claims data can be mined to develop retrospective assessments of quality, using health care professionals to analyse treatment patterns. Service quality, defined by indicators such as hours of operation or scope of services offered, may also be measured.

Subjective quality of care, sometimes referred to as the patient experience, typically reflects patients' perspective as to how they value the health care they received. Subjective views may be measured through surveys or focus groups on a range of topics such as comfort of facilities, perceived attitudes of health care providers, value for money, etc.

Promoting clinical quality through medical advisors

Case studies show that medical advisors can play a key role in measuring quality of care against defined standards, especially when a health care provider is not directly engaged in claims and care management. A medical advisor monitors quality of care with health care providers through these main functions:

- Assessing the extent to which insured patients receive appropriate health care services according to diagnosis and health status.
- Screening and periodically auditing of the general quality of care in contracted health care facilities.

- Implementing and monitoring compliance with standard treatment protocols.

Promoting service quality through liaison officers

All case studies reviewed confirm that clients may perceive greater quality in a HMI scheme when a liaison officer assists them to access care and to submit claims. Liaison services can increase the perception of value and quality and in turn increase trust in the scheme and encourage renewals, contributing to the scheme's sustainability. They have a cost, however, so HMI schemes must evaluate when and how to efficiently provide such services. An optimal arrangement may be achieved by providing a liaison at facilities that have a minimum number of clients or claims. Another cost-effective strategy can be for a liaison officer to cover several facilities on a rotating basis, or only during peak hours. Technology developments such as the spread of mobile phones have also stimulated development of call centres which can remotely provide many of the liaison services desired, at a considerably lower cost.

Ensuring timely payment to health care providers

In a context where health care providers often struggle to maintain sufficient cash flow to fund operations, many experts interviewed commented on the importance for HMI schemes with a TPP mechanism to make timely payments to providers. Contracts with health care providers typically stipulate the terms for payment, including the maximum time allowed for payment of capitation or claims. Failure of a TPP mechanism to honour contractual terms can lead to refusal by health care providers to treat patients or to demand pre-payment, which can damage the HMI scheme's reputation amongst both clients and health care providers, and may even result in contract termination. Managing quality under a TPP mechanism therefore includes paying health care providers on time.



CONCLUDING THOUGHTS

Various health care provider payment options have different pros and cons to successfully support TPP arrangements. Payment options (e.g. case-based, per day or capitation) that transfer some financial risk to health care providers have greater potential to contain costs than fee-for-service payment, but are more difficult to negotiate with health care providers and can increase HMI scheme administrative costs. More importantly,

HMI practitioners highlight that operating successful TPP mechanisms goes beyond the provider payment method. Other critical success factors include: ensuring access to health care, creating viable long-term partnerships with providers, limiting moral hazard and fraud, and managing clinical and non-clinical aspects of quality of medical care. Implemented properly, TPP mechanisms can increase value for low income clients and health care providers, while contributing to the sustainability of HMI schemes.

Housed at the International Labour Organization's Social Finance Programme, the **Microinsurance Innovation Facility** seeks to increase the availability of quality insurance for the developing world's low income families to help them guard against risk and overcome poverty. The Facility was launched in 2008 with the support of a grant from the Bill & Melinda Gates Foundation.

See more at www.ilo.org/microinsurance



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